

ACTIVE TREATMENT CHECKLIST - AGES 0 TO 16

The need for active treatment is based on the professional judgment of the interdisciplinary team.

Child's Name: _____ MID#: _____ Date: _____

Fill out the following form to determine if the child requires active treatment.
A child must require active treatment to qualify for ICF/ID level of care.

1. The individual is functioning below age levels and is not responsive to typical parenting strategies; and/or	Yes No
2. The interventions used with the individual address limitations that are not typical of individuals the same age; and/or	Yes No
3. The individual is not able to conduct himself in an appropriate manner (behaviorally and functionally) during unsupervised or non directed activities; and/or	Yes No
4. The individual is not able to apply skills learned in a training environment to other settings; and/or	Yes No
5. The individual requires a range of professional services and the supports and resources of a comprehensive and specially designed program which is consistently and aggressively implemented in order to make progress or maintain current functional level; and/or	Yes No
6. The individual requires more supervision than is generally required of persons of the same chronological age.	Yes No

Annual Review Date: _____ QIDP/IAP: _____

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*****This form may be used for up to three (3) years if the documentation indicates that there is no substantial change in the person's status which would impact eligibility. It must be signed and dated each year by the QIDP/IAP to indicate that all of the pertinent documentation has been reviewed.***